SPECIAL ARTICLE

Barriers in the mind: promoting an economic case for mental health in low- and middle-income countries

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In recent years, policy makers in high-income countries have placed an increasing emphasis on the value of maintaining good mental health, recognizing the contribution that this makes to quality of life, whilst ever more mindful of the socio-economic consequences of poor mental health. The picture in many other parts of the world is much less encouraging; policy attention and resources are still directed largely at communicable diseases. We reflect on some of the challenges faced in these countries and outline the role that economic evidence could play in strengthening the policy case for investment in mental health. Clearly this should include assessment of the economic impact of strategies implemented outside, as well as within the health sector. The ways in which mental health services are delivered is also of critical importance. Non-governmental organizations (NGOs) have long been shown to be key stakeholders in the funding, coordination and delivery of these services in high-income countries. Their role in low- and middle-income countries, where infrastructure and policy focus on mental health are more limited, can be even more vital in overcoming some of the barriers to the development of mental health policy and practice.

Key words: Mental health policy, economics, service development, non-governmental organizations

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The 2001 World Health Report made plain the global challenge posed by poor mental health. Worldwide, 20% of individuals may experience mental health problems during their lifetime, and such disorders account for approximately a third of all years lived with a disability (1). The consequences of poor mental health range far and wide, of course; they are associated with higher rates of non-mental health-related comorbidity and premature mortality. Some mental health problems are also associated with poor employment experiences, poor personal relationships, strain on families, and a higher-than-average risk of homelessness and contact with the criminal justice system.

The 2001 report helped to raise awareness of the importance of mental health. The need to promote and maintain good mental health and well-being as integral elements of health policy is now quite widely recognised in high-income countries. For instance, the European Commission published in 2005 a Green Paper on mental health (2) and all 52 Member States in the European Region of the World Health Organization (WHO) endorsed a Declaration and Action Plan at Helsinki earlier that same year (3,4). In the United States, a Presidential Commission called for investment in actions to ensure that mental health receives the same level of attention as physical health problems, specifically recommending actions to tackle suicide and reduce stigma, as well as interventions to promote child mental health (5). Positive actions can also be seen in the Pacific region, where, for instance, New Zealand has a ten-year national mental health strategy (6), with implementation monitored by a separate Mental Health Commission.

The picture in many other parts of the world is much less encouraging. Although there has been some recent focus on the need to tackle the mental health consequences of major disasters such as the Asian Tsunami (7), policy attention and resources in many low- and middle-income countries are still directed largely at communicable diseases.

The purpose of this paper is to reflect on some of the challenges faced in low- and middle-income countries and the role that economic evidence could play in strengthening the policy case for investment in mental health. There is obviously a need to improve our understanding of the cost-effectiveness of specific interventions within the health care system. But there is also a pressing need to expand the role of economic analysis in looking at non-health sector interventions that can have a direct impact on mental health or can indirectly help with the uptake and maintenance of treatment. The ways in which services are delivered are of critical importance and also need evaluation. In particular, we shall argue that non-governmental organizations (NGOs) can be key players in the funding, coordination and delivery of services.

THE SOCIO-ECONOMIC IMPACT OF POOR MENTAL HEALTH

The burden of mental illness is predicted to increase from its current level of 12% of global disease burden to approximately 15% by 2020; much of this additional burden is projected to occur in low-income countries (8). The consequences of poor mental health in low-income countries may be even worse than in high-income ones, because of the absence of social protection safety nets, compounded by the high levels of stigma and superstition (9). The cycle

between poor mental health and poverty in low-income countries has been observed in several studies (10-12). Poor maternal mental health also has long-term adverse consequences for infants in low- and middle-income countries, limiting their own lifetime opportunities (13). Communicable diseases, the focus of much health policy in poorer countries, are also inextricably linked and exacerbated by poor mental health; interventions to prevent and treat mental health problems could help in the management of these conditions, as for instance in the case of HIV/AIDS (14,15).

The economic costs of poor mental health are well documented in high-income countries, conservatively estimated to account for between 3% and 4% of gross domestic product (GDP). Few estimates have been made outside the developed world. One exception is a study in Kenya (16) that estimated that the total costs per patient for 5,678 individuals with mental health problems hospitalised in 1999 were US$ 2,351. This included out of pocket costs to family members of US$ 51 and productivity losses of US$ 453. Total economic costs for this group alone were more than US$ 13.3 million, equivalent to 10% of the Ministry of Health's budget; yet these figures would have been substantially larger if costs had also been included for those individuals who were not institutionalised or were treated by traditional healers. To put this in context, the average income per head of the population in Kenya is just US$ 580 per annum, and more than half the population live on less than US$ 1 per day (17).

Other examples can be found in India, where the overall costs for outpatients with schizophrenia have been found to be similar to those of people living with another long-term condition, diabetes; a key difference between them, however, is the much greater contribution of indirect costs to overall costs (63% versus 29%) in the case of schizophrenia. This included not only the costs of lost opportunities to work for the individuals with the illness and their families, but also the loans taken out to meet the costs of treatment and money spent on repairing damage to property. In total the annual cost per outpatient treated for schizophrenia was estimated to be US$ 274 (18). Another Indian study where free access to essential drugs was provided as part of community outreach services for people with schizophrenia reported that these led to a number of improvements in quality of life over an 18-month period. The impact on cost was modest, with the investment in community outreach services partly offset by a reduced need for caring by family members (19).

This impact on family caregivers can be considerable. In Ethiopia, Shibre et al (20) looked at the impact of schizophrenia on 300 family caregivers in traditional rural communities. Relatives experienced financial difficulties, constraints on their social life, reduced opportunities to work and strained family relationships. These problems were particularly challenging for female caregivers. Similarly, a study of 66 caregivers in Zimbabwe reported that two-thirds experienced financial difficulties, especially as food consumption by their relative increased (21).

THE ROLE OF ECONOMIC EVIDENCE

Some people have argued a moral case for greater investment in mental health, given the high number of individuals affected and the ensuing profound consequences (22). Such a case obviously needs substantiating with evidence that targeting more investment on mental health will be effective in preventing or treating mental disorders, and that it represents a cost-effective use of a country's scarce resources. In turn, this generates a need for economic analyses to support clinical and strategic decision-making. Of course, decisions should never be made on the basis of cost or cost-effectiveness alone, and other factors such as fairness, human rights and ethics are usually highly relevant.

There has been significant growth in the evidence base on the effectiveness and cost-effectiveness of interventions aimed at treating the consequences of poor mental health (particularly drug therapies) (23-26). Increasingly, economic analyses are being undertaken in low- and middle-income countries (27-31), but the overwhelming majority of studies are from high-income countries. This is not surprising: between 1992 and 2001 only 4% of articles in journals on the ISI Web of Science databases were on mental health issues; of these a mere 6% were from low- and middle-income countries (32). Similarly, Patel and Kim (33) found, from their review of publications between 2002 and 2004 in six leading journals, that only 3.7% of papers were from low-income countries. Unfortunately, economic evaluation findings do not transfer easily between countries, because infrastructures, resources, incentives and cultures can be very different. There is therefore a need to develop the evidence base on the effectiveness and cost-effectiveness of interventions in low- and middle-income countries through additional empirical studies. Practically, however, even with a substantial injection of funding, this evidence base will take some time to emerge, given the human and infrastructure capacity constraints within countries (34).

In the meantime, how can economics best be used to inform policy making? In the absence of empirical evidence, careful use of economic "models" which seek to adapt evidence on effect to take account of different local circumstances and cost structures can play a role. The most significant such endeavour is the ongoing work of the WHO CHOICE (Choosing Interventions that are Cost Effective) Programme. CHOICE aims to assess the cost-effectiveness of a wide range of interventions for conditions that make significant contributions to the burden of disease in a range of epidemiological and geographical settings. The core aim is to feed information into the policy process (35).

Thus far, the CHOICE programme has looked at schizophrenia, bipolar disorder, depression and panic disorder. It has estimated, for example, that cost-effective interventions can be provided for US$ 3-4 per capita in low-income settings of Sub-Saharan Africa and South East Asia, or around US$ 10 in middle-income regions such as Eastern Europe. These are typically a combination of older off-patent an-

tipsychotic or mood stabilising drugs plus psychosocial therapy. It has also been estimated that, globally, between 300 and 500 million healthy years of life could be gained for each additional US$ 1 million invested. Around one third of the gains would be for severe mental disorders, schizophrenia and bipolar disorder, with the most cost-effective interventions being for depression and panic disorder (36).

Welcome though the CHOICE programme is, it has focused largely on health care interventions to improve mental health outcomes, although there is in high-income countries a growing body of evidence related to the role of employment and living arrangements. There is an urgent need to assess the cost-effectiveness of prevention and promotion strategies, many of which lie outside the health system, for example in the school or workplace. There is also very little research evidence from low- and middle-income countries on how poverty and related socio-economic factors impact on the success of mental health policy and practice. Do these broader developmental issues have an opportunity to influence mental health policy thinking?

BARRIERS TO INVESTMENT IN MENTAL HEALTH

Despite the substantial adverse impact of poor mental health and the emerging evidence base on the availability of potentially cost-effective interventions, there remain many difficulties in trying to ensure that mental health both receives a fair level of investment in low- and middle-income countries and that, when services are available, there is fair access to them.

Low policy priority

Historically, mental health may have appeared to be a low priority for both national policy makers and external donors. Rather symbolic of this was the fact that the World Bank's 1993 World Development Report highlighted that poor mental health was a major contributor to the global burden of disease, but its recommended minimum essential services package (ESP) for health services did not seek to address mental disorders, even though their overall burden was twice that of ESP priority areas tuberculosis and HIV/AIDS (37). This omission generated some criticism and was addressed in a later version of the ESP.

Nonetheless, it remains the case today that in both low- and middle-income countries the focus of much health policy (and international assistance) has been geared towards communicable diseases that lead to premature mortality, most notably HIV/AIDS, malaria and tuberculosis. Substantial international efforts have been launched, such as the "3 by 5 Initiative", aimed at providing greater access to drug therapy for AIDS. The Millennium Development Goals explicitly recognize the contribution of good health towards economic growth, and include several health-related targets, yet mental health is noticeable by its absence, despite the production of background papers prepared for the Commission which emphasized the strong links between poverty, lack of economic growth and poor mental health (38,39).

This low perceived priority is exacerbated by stigma. This undoubtedly has contributed to a lack of attention from policy makers and the public alike, in turn leading to a lack of resources, poor staff morale, decaying institutions, lack of leadership, inadequate information systems and inadequate legislation (40).

Absence of needs-based policy assessment

Even if policy-makers give greater priority to mental health, a key constraint on the development of services and their allocation so as to meet needs is the lack of epidemiological data. This situation is not confined to low-income countries: one recent review could not find adequate prevalence data on mental disorders in 13 of the 25 European Union Member States (41). Unfortunately, the infrastructure required to provide such information is not insignificant.

Moreover, in the assessment of needs it is important not to rely solely on epidemiological data. The views of all stakeholders need to be considered; yet it remains rare for people with mental health problems and their advocates to have an opportunity to participate in or inform the policy process. As a result, there is a danger that policy gives insufficient emphasis to measures that can alleviate some of the broader impacts of mental disorders, such as lost opportunities to work or to participate in education. There is also the risk that policy makers fail to appreciate the challenges of implementing programmes on the ground.

Diagnosis of disorders

Primary health care professionals may lack the training to recognize mental health problems. Depression in particular may be poorly recognized (and thus not treated) in many low-income countries (42). One study from Zimbabwe suggested that over 90% of primary health care workers acknowledged deficiencies in the recognition and knowledge of treatment for depression (43). Lack of knowledge among health care professionals may be compounded by the stigmatization of mental illness, with some studies indicating that many professionals believe that such conditions either do not exist or cannot be treated (44). Stigmatization might also mean that only physical symptoms or comorbid conditions are treated, rather than the underlying disease.

Insufficient resources

Countries accounting for more than 2 billion of the world's population spend less than 1% of their total public

sector health care budgets on mental health (45). The majority of countries in Africa are in this category. Only 51% of the world population in low-income countries have access to any community care services (45). Evidence on utilization of mental health services is limited, but at least 85% of people with severe mental health problems do not receive treatment within any 12-month period in some low-income countries (46). One recent community-based survey in Nigeria found that only 9% of people with DSM-IV disorders received some type of formal treatment for mental health problems during a one-year period (47). In Sao Paolo, Brazil, where the overwhelming majority of people with schizophrenia are covered by the public system, it has been estimated that over 70% still do not make use of services (48).

Even where there is a political commitment to fund mental health, the level of available resources will be dependent on the state of the economy. So, even if more than 5% of the total health budget is allocated to mental health, this will not amount to much in terms of overall resources if the overall level of national income is low. The need to keep public finance under control or to make loan repayments might also mean that public services have to be cut; mental health services may be particularly vulnerable in such circumstances.

Access to drug therapy remains limited: worldwide, the WHO found that, by 2001, 20% of all countries were not providing at least one antidepressant (amitryptyline), one antipsychotic (chlorpromazine) and one antiepileptic (phenytoin) (45). This situation is unlikely to be helped by the enforcement of World Trade Organization's Trade Related Intellectual Property Rights (TRIPs) agreement. Under this agreement no country can produce cheap generic bioequivalent versions of patented drugs and furthermore the price of patented drugs must be set by the manufacturer (49). While there are some exemptions to these rules for national emergencies and diseases which are life threatening, there are no exemptions for mental disorders. In addition, a number of bilateral free trade agreements have been signed between the US and some developing countries. These agreements can be even stricter than TRIPs, for instance extending the period of patent protection (50). There are also human resource challenges, especially since health systems have to contend with the lure of high countries that can offer better pay and conditions to these professionals.

Different but equally pertinent challenges confront the middle-income countries of the former Soviet Union. Here a major problem continues to be the high rates of suicide and alcohol-related disorders, which may stem partly from rapid economic and social transition (51). Existing mental health services are being put under great pressure as public resources for health systems decline. Moreover, the supplementary private health insurance arrangements purchased by many people to cover gaps in tax-funded health care systems typically do not provide cover for long-term mental health problems.

Financial barriers to access

The extremely limited budgets for mental health in many low- and middle-income countries inevitably mean that access to many services is dependent on payment at the point of use. Around 40% of low-income countries reported out-of-pocket payments to be the primary method for financing mental health care, compared with only 3% of high-income countries (45). Even this figure of 40% is undoubtedly conservative, as it does not take account of costs incurred through consultation with traditional healers. This reliance on out-of-pocket payments is both inefficient and inequitable, as it discourages utilization of services by those with limited incomes, which is especially worrisome given the close links between poverty and poor mental health (52). Paying for services may lead to poverty or indebtedness if families borrow from moneylenders at very unfavourable terms. Opportunities to reduce some of the externalities associated with poor mental health are thus lost.

Optimizing use of available resources

A number of challenges in making use of resources have been set out on detail elsewhere by Knapp et al (53). While these barriers may also be applicable to health systems generally, they are likely to be more difficult to overcome in mental health contexts. Indeed, their impact may be greatest in low- and middle-income countries, where human and financial resources are scarce and where there are many competing claims on available resources.

Two of these barriers have already been discussed: the paucity of information on effectiveness and cost-effectiveness, and the limited level of resources committed to mental health treatment and care. Another key factor is the poor distribution of available resources, which are often heavily concentrated in urban areas. The distance to be travelled to reach a community-based mental health facility can be substantial: in one Indian study a key reason for the lack of continued use of antipsychotic medication was the need for individuals to have to travel more than 10 kilometres to their nearest outreach clinic (19). In some rural areas of South Africa there is only one psychiatrist per 5 million population (54). Changing migration patterns, particularly from rural communities to urban areas, can also act as a barrier to sustaining treatment. Seasonal migration in India is significant, with the National Sample Survey of 1999-2000 estimating that 8.64 million people migrated seasonally for short periods (55). Resources may also be distributed inefficiently across different disorders or needs. Historically, for example, depression has been viewed as a lower priority compared to schizophrenia within the health systems of developing countries (56).

There is also the problem that resources are used inappropriately to support services that do not match epidemiological needs or the preferences of service users or the ev-

idence base on effectiveness and cost-effectiveness. The WHO (54) has recommended the development of primary care-led mental health systems, where mental health is fully integrated into the health system; countries which continue to rely heavily on institutional-based care are unlikely to be providing an appropriate mix of services.

Resource inflexibility is a related concept: it may prove difficult to reorganize and move resources so as best to meet population needs. Health systems may be highly bureaucratic, with little opportunity for decentralization or local management of funds. In countries where most resources are "locked" within a highly institutionalized system, as in the former Soviet Union, it can be extremely difficult to release resources from institutions to fund community-based alternatives (57).

The uptake of community outreach services might also be poor because of the practical problems of poverty-related food insecurity, lack of transportation and financial resources. To ensure a course of treatment is successfully completed may require dealing with food insecurity: one survey in Zimbabwe suggested that more than 10% of family carers could not afford to pay for the additional food required for relatives with mental health problems (21). It is important therefore to ensure that unused resources are not wasted, and furthermore for policy-makers to think not only about clinical strategies but also about some of the factors that might limit the use of services.

Where there is decentralized responsibility, as in India, local governance structures need to have the skills to ensure that funds are allocated to mental health. Resources may also be held by a number of different budget holders, not only health, but also education, employment and social welfare. Poor coordination and cooperation between central and local governments and NGOs can hamper the development of flexible services. In Zambia, for example, the collapse of both primary and community services for mental health was attributed to a lack of coordination (58).

Policy makers also need to be aware that reconfiguration of existing services or greater investment does not necessarily mean that there will be immediate improvements in mental health outcomes. Investing in workforce development may take several years to generate benefits in terms of better treatment and care. Politically, policy makers may therefore be tempted to concentrate on areas of the health system where more visible and immediate benefits can be generated, even if the need for them is lower. A related issue is the need to ensure that there is a sufficient long-term commitment to service delivery, so as to support vulnerable individuals over time within their communities.

MEETING THE CHALLENGE

Clearly one need is to improve access to information on both effectiveness and cost-effectiveness of interventions to treat mental health symptoms. Improved understanding of population needs is also important. Other information deficits that need to be addressed include finding affordable and cost-effective ways to deliver mental health training to primary care and other professionals, and launching awareness initiatives and anti-discrimination measures to tackle some of the consequences of stigma. Plugging the information deficit and making more efficient use of scarce resources would go some way to strengthening the arguments for mental health.

Having a better understanding of how resources are allocated to mental health and other health priorities would also be helpful. In many instances where national health budgets are tiny, there is high dependence on external sources of funding for health programmes. Some insight into the ways that external donor programmes and international aid organizations are involved in setting priorities in health and other sectors would help if a case is to be built for more investment in mental health. Creating opportunities for mental health service users and other stakeholders to participate in the drafting of Poverty Strategy Reduction Papers would also be desirable, particularly as many of these papers appear to focus almost exclusively on physical health.

Initiatives that have helped emphasize the integration of physical and mental health objectives in different settings might also help build the case for greater resources for mental health programmes. Investment in mental health can also benefit physical health. More engagement with mainstream NGOs that focus on physical health issues might help encourage their involvement in mutually beneficial mental health and psychosocial programmes. One exploratory review of 19 UK-based international NGOs concluded that many felt they did not have the skills to address mental health needs and were in favour of greater collaboration with NGOs that specialized in the mental health field (59).

It is important also to expand the role of economic analysis to look at the potential cost-effectiveness of initiatives to tackle macroeconomic risk factors for poor mental health, such as poor living conditions, financial insecurity, rapid economic transition and low levels of education. For instance, what benefits to mental health might be achieved through the operation of fair credit schemes in low-income countries? Again, the benefits of such initiatives will not be restricted to mental health alone, so that a partnership approach illustrating all health (and non-health) benefits would be merited.

The way in which effective interventions are delivered and/or funds channelled to mental health-related activities is also of importance. One issue here is the organization and financing of public health (and other) systems. There is a substantial body of literature in place looking at approaches to address the fragmentation of service delivery and the need to coordinate services across different sectors (53).

Funds cannot simply be transferred from inappropriate long-stay institutional care facilities to community-based alternatives. In the short to mid-term, additional funding will be required so as to continue to operate existing services un-

til new community based services are developed and become operational. Pragmatic initiatives which seek to ensure existing long-stay institutions have funding to be transformed so as to also provide primary mental health care services, as with the Butabika hospital in Uganda, may also merit further development (60).

The high reliance on out-of-pocket payments is a major barrier to access to treatment, and countries should be working towards health finance systems built on tax-funded or social insurance prepayment schemes. A major challenge, however, is that the structures for revenue collection often do not exist in low-income countries (52). Less ambitious initiatives, such as very local community insurance schemes, might represent a way forward.

Delivery mechanisms also need attention. Although the CHOICE programme does take into account the rate of uptake of services, few economic evaluations conducted in low- and middle-income countries have considered this issue. What are the barriers to service use, such as lack of transportation? Would it be prudent to tackle these barriers, and if so how? Many services are delivered by NGOs, but there is a paucity of information on the quality, effectiveness or cost-effectiveness of the services they offer. Can they, as it has been shown in high-income countries, offer flexible, innovative services that can meet the needs of local populations in ways that public services often cannot (61)? How do NGO programmes compare with public and private (for-profit) alternatives? Can their involvement with local communities, perhaps through the participation of volunteers, encourage greater uptake and use of services compared with government-run programmes? To whom and how accountable are they? These are key questions to which we now turn.

The roles of NGOs in meeting the mental health challenge

Many countries report that they have some NGOs working in the field of mental health. Faith-based health services (missions) were early providers of care in many countries, while more recently, secular NGOs (international or national) have also come to play significant roles. These organizations may be self-funded or receive support from local government, external donors or other NGOs. Some may also play significant roles in training, resource provision and policy advocacy.

At international level, it is difficult to identify NGOs that specifically focus on mental health. One recent survey looked at NGOs that provide emergency mental health services following disasters as well as developmental services. Of 119 English language organizations listed on the United Nations website www.reliefweb.int, only 55 (46%) reported being engaged in mental health programmes. Forty-seven of these had engaged in at least one long-term developmental programme, but only four were deemed to provide comprehensive international mental health programmes (62).

There are prominent exceptions, including the US-based Carter Center's mental health programme, and the Budapest-based Mental Disability Advocacy Centre. Such organizations may not only raise and distribute funding for mental health, but also help to deliver services. Another example is Basic Needs, which works in partnership with government health units to help deliver mental health services at primary care level in several programme sites across seven countries in Africa and Asia (Ghana, Kenya, India, Lao People's Democratic Republic, Sri Lanka, Tanzania and Uganda).

NGOs can address some of the barriers to the development of mental health policy and practice, for example by helping to raise awareness of the importance of mental health and by stimulating demand for access to services in low-income communities. A community development or grassroots approach, which involves engagement within local communities with key stakeholders including service users and their families, is often used because of the challenges in translating dialogue at a high political level into action on the ground (63).

The community partnership model that NGOs often adopt can help build on social capital in communities to support the work of primary health centres. Local volunteers and village health workers can be trained, undertaking follow-up of service users to ensure regular use of medicine, monitoring side effects and relapse, as well as maintaining and updating records. NGOs can also act as bridges between traditional healers and conventional medicine. For example, Basic Needs has engaged with traditional healers as one of their target stakeholder groups in Northern Ghana, where some of these healers have subsequently begun to refer some people with mental health problems to health services staff.

Such partnerships between the NGO and the statutory sectors provide opportunities for health professionals, especially psychiatric nurses, to enhance their skills. Ongoing access to psychiatrists can help in developing a deeper understanding of how to meet mental health needs in community contexts. Through a greater level of contact with people with mental health problems within local health care systems, local health personnel may make requests at district or regional levels for drugs and other services to meet these previously hidden local needs.

Partnerships with NGOs can also be helpful for the heads of government mental health services. They can act as catalysts to respond to often long-standing demands for greater investment. In one country where Basic Needs operates, for example, the chief psychiatrist was hopeful that starting a mental health and development programme would help to move mental health up the government agenda. This partnership approach has very gradually begun to bear fruit, including a commitment of 55 million Uganda shillings (approximately US$ 30,157) for mental health in Kampala, and a joint World Bank/Ministry of Health project, developed with Basic Needs inputs, in Sri Lanka to develop community partnerships in the Uva and North Western provinces.

CONCLUSION

Mental health problems are a major contributor to the global disease burden, they are associated with premature mortality and profound socio-economic impacts on individuals, and they generate substantial costs to the economy. Despite the availability of proven cost-effective interventions in high-income countries and some more limited but accumulating evidence in low- and middle-income countries, mental health promotion and care have been widely neglected when compared with levels of investment in interventions for somatic health disorders. Even where funding is available, access to and utilization of services may be poor, even if payment systems are ostensibly fair (which, of course, they generally are not).

A combination of factors, some almost unique to mental health, has contributed to these inequities. Stigmatization, lack of empowerment within a highly vulnerable population, abuse of individual human rights and reluctance to change historical allocations of resources have perpetuated a situation in which the opportunity to prevent and alleviate mental health problems has so far largely been missed.

Overcoming these challenges requires a multi-dimensional strategy. Economic analysis of the cost-effectiveness of interventions can play a role in this strategy. Such analysis needs to look beyond interventions that address the symptoms of mental disorders alone; a better understanding is also needed of the health system (broadly defined) and the cultural and socio-economic contexts in which interventions are to be delivered. Economic analysis is also needed of more holistic strategies to address risk factors for poor mental health, such as poverty, lack of access to fair credit and interrupted education. Effective strategies will have benefits that go beyond mental health, and partnerships with other groups are merited, such as those working with communicable diseases.

Analysis of the implementation process is potentially helpful. In countries where government health systems are weak and/or poorly funded, and where mental health is a low priority, NGOs can play vital roles. If some of the benefits of working with NGOs can be assessed more systematically, this might help strengthen the case for investment in mental health. International agencies have long worked, with some success, in the areas of malaria, tuberculosis, HIV/AIDS and maternal and child health. What, then, is more difficult or different in looking at mental health problems in the same villages and often in the same families? The emerging experience from NGOs such as Basic Needs indicates that even modestly resourced efforts can have some impact, which in turn suggests that the neglect of people with poor mental health in low-income countries is not as insurmountable as is sometimes inferred at the policy making level.

Perhaps the key difference between mental disorders and other health concerns is that the former are more often viewed as a low priority because they are perceived as less life-threatening. Too often mental health only comes to the attention of local policy makers after a terrible global tragedy such as the Asian Tsunami or a high profile local event such as the fire in Erawadi, India. The latter resulted in the deaths of 25 people who had been left chained within a private psychiatric asylum. A subsequent Commission provided the impetus for mental health policy directives and initiatives by state and central governments, NGOs, and even the supreme court of India. But as these events fade from memory, it is easy for mental health to slip off government and NGO priorities for action. Getting the message across that investment in mental health can generate economic as well as quality of life benefits is vital to its inclusion on the agenda for economic development. This is no easy task, since barriers to effective mental health care start with barriers in the mind.

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